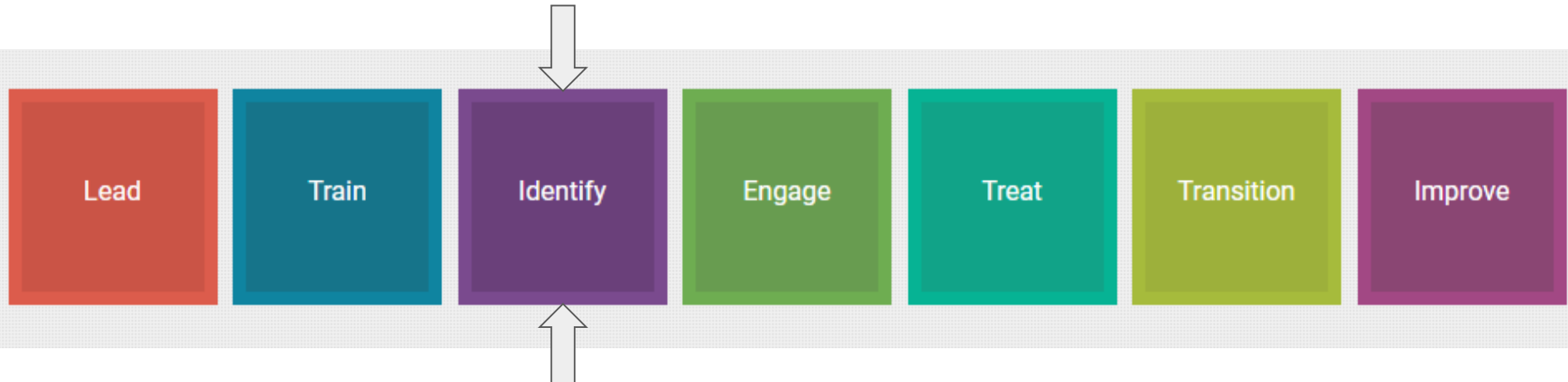


# Screening & Assessment

Utah Zero Suicide Learning Collaborative

March 21, 2018



# Check In From Last Meeting

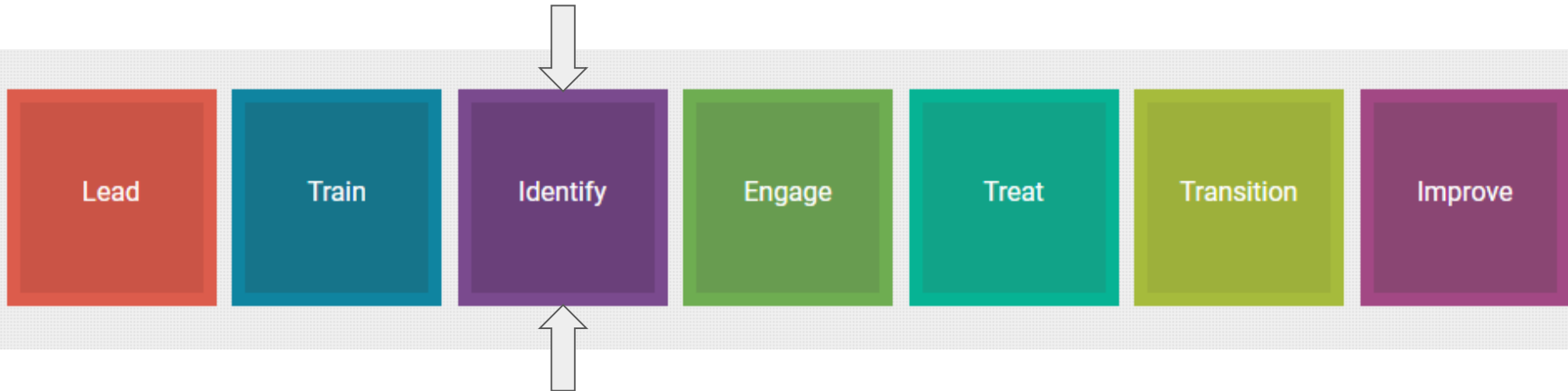
50% of those who responded to the survey say that their organization has formally adopted Zero Suicide

33% said that they have completed the Organizational Self Assessment and the remaining 67% said that they plan to do so.

# ZS Approach to Screening and Assessment

In a Zero Suicide organization, all patients are screened for suicide risk on their first contact with the organization and at every subsequent contact. All staff members use the same tool and procedures to ensure that clients at suicide risk are identified.

The standard of care in suicide risk assessment requires that clinicians conduct thorough suicide risk assessments when patients screen positive for suicide risk and then make reasonable formulations of risk and appropriate plans for care.



The purpose of the screening is not to *predict* suicide  
but rather to *plan* effective suicide care.



# Why Universal Screening

“Universal suicide risk screening in the ED was feasible and led to a nearly twofold increase in risk detection. If these findings remain true when scaled, the public health impact could be tremendous, because identification of risk is the first and necessary step for preventing suicide (Bourdreaux et al., 2016).”

Approximately two-thirds of patients with depression present to primary care with somatic (physical) symptoms only (Tylee & Gandhi, 2005).

45% of individuals who died by suicide were seen in primary care within the month before their death (Abed-Faghri, Boisvert & Faghri, 2010).

Bourdreaux ED, Carmargo CA Jr, Aria SA, Sullivan AF, Allen MH, Goldstein AB, Manton AP, Espinola JA, Miller IW. Improving suicide risk screening and detection in the emergency department. *American Journal of Preventative Medicine*. 2016; 50 (4), 445-453. doi: 10.1016/j.amepre.2015.09.029.

Tylee A, Gandhi P. The importance of somatic symptoms in depression in primary care. *Primary Care Companion to The Journal of Clinical Psychiatry*. 2005; 7 (4), 167–176.

Abed-Faghri, N., Boisvert, C.M., & Faghri, S. (2010). Understanding the expanding role of primary care physicians (PCPs) to primary psychiatric care physicians (PPCPs): Enhancing the assessment and treatment of psychiatric conditions. *Mental Health in Family Medicine*, 7(1), 17-25.

# Why Universal Screening

The American Pediatric Association Committee on Adolescence (2007) recommended that

**“Primary care pediatricians should be comfortable screening for suicide and mood disorders by asking about emotional difficulties, identifying lack of developmental progress, and estimating level of distress, impairment of functioning, and level of danger to self and others.”** “self-administered scales can be useful for screening, because **adolescents may disclose information about suicidality in self-report that they deny in person**”

**Primary care providers are the largest prescribers of psychotropic drugs** – according to a one-year National Prescription Audit (NPA), while psychiatrists and addiction specialists prescribed 23% of all total psychotropic drugs, general practitioners and other non-mental health specialists prescribed 59% of all total psychotropic drugs (Mark, Levit, & Buck, 2009).

# Why Universal Screening

## **The Joint Commission**

"The Joint Commission aims to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation. Clinicians in emergency, primary and behavioral health care settings particularly have a crucial role in detecting suicide ideation and assuring appropriate evaluation."

# Universal Screening

What barriers or concerns does your organization face?

Time restraints

Clinician lack of confidence in their skills to assess and manage risk

Lack of timely patient access to referral resources

NA - we already implement universal screening successfully

Lack of buy in regarding the importance of universal screening

Liability concerns



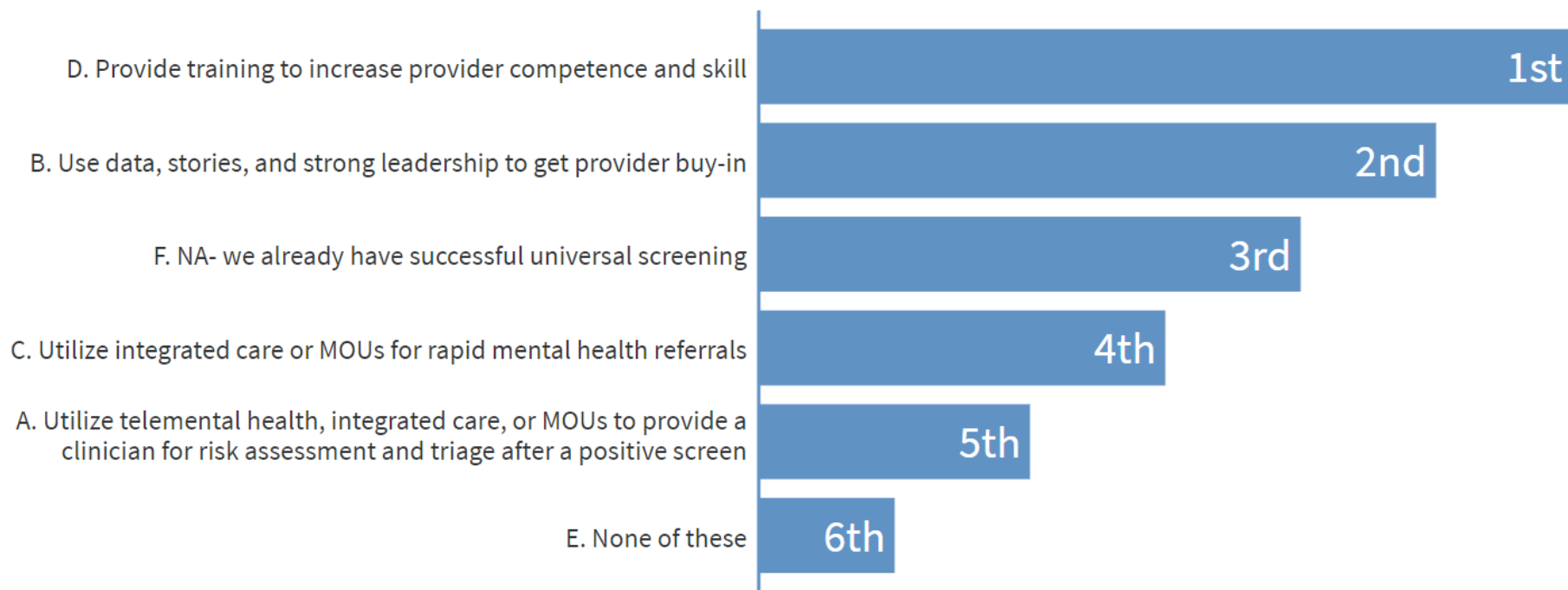
# What solution(s) would be most likely to make universal screening possible for your organization?



When poll is active, respond at **PollEv.com/andreaahood726**



Answers to this poll are anonymous



# Solution to Overcome Barriers:

Develop clear policies, procedures, and culture around screening, assessing, and managing risk, and train providers continuously in these procedures to improve confidence.

Use data and stories to get buy in; and have strong, united leadership.

Develop MOUs for rapid referral, telemental health, integrated care, or other resources to support physicians and provide continuity of care.

*“Develop clinical environment readiness by identifying, developing and integrating comprehensive behavioral health, primary care and community resources to assure continuity of care for individuals at risk for suicide”* Joint Commision Sentinal Event Alert 2016

# Suicide Screening vs. Suicide Assessment

Screening is a procedure in which a standardized instrument or protocol is used to identify individuals who may be at risk for suicide.

Assessment is more comprehensive evaluation done by a clinician to gather information about the patient's context and history, estimate the immediate danger to the patient, and decide on a course of treatment to increase safety, reduce risk, and promote wellness and recovery.

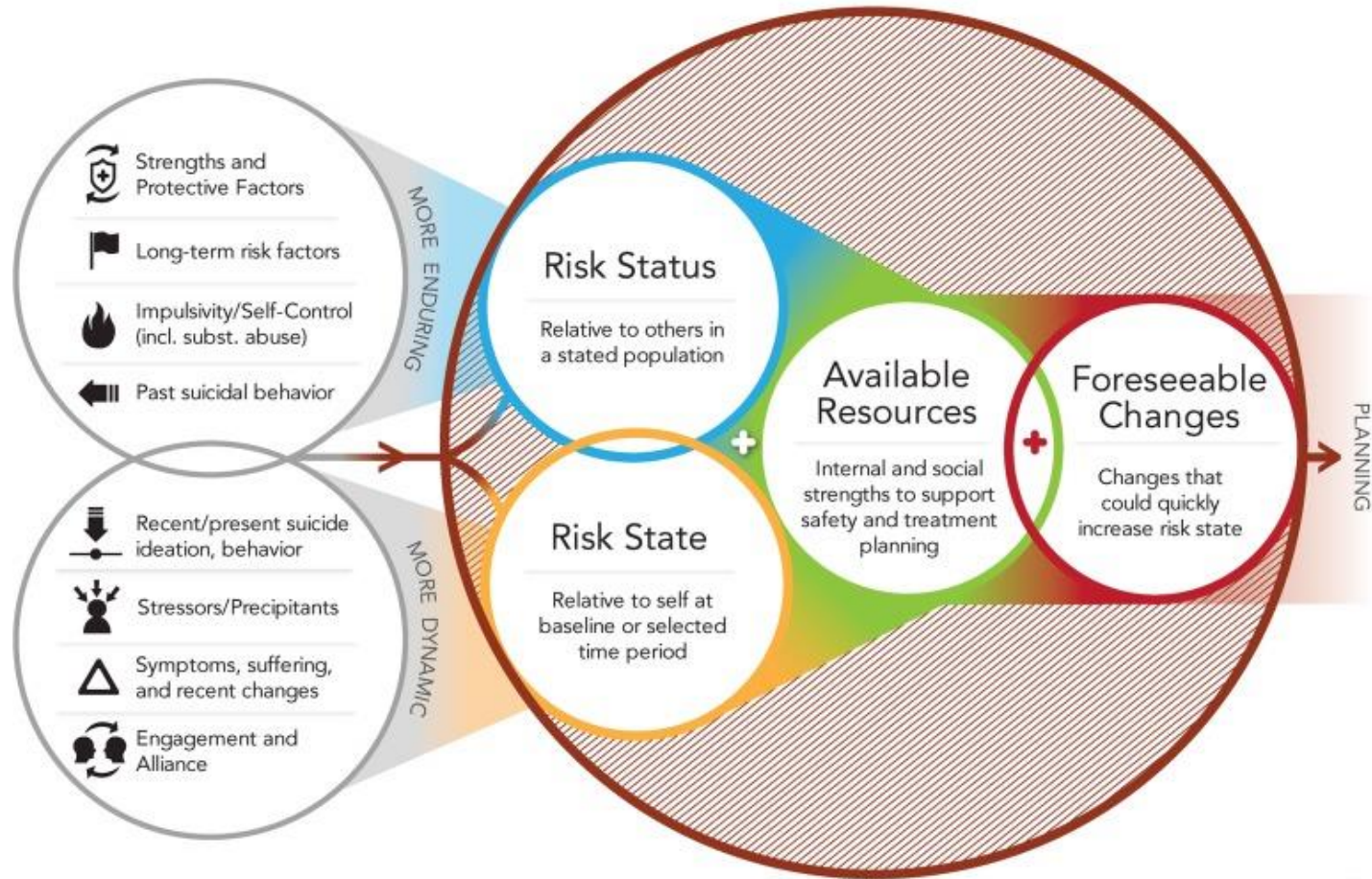
Use of standardized tools is likely to elicit more relevant information, help information be communicated clearly, and create consistency

The purpose of the assessment is not to *predict* suicide  
but rather to *plan* effective suicide care.



# Clinical data

# Risk Formulation



# Responding to Identified Risk

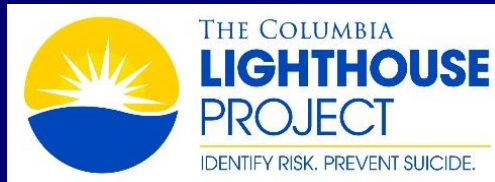
Next Meeting (May 16) will focus on this topic. But just to get you thinking:

“Response to item 9 of the PHQ-9 for depression identified outpatients at increased risk of suicide attempt or death. This excess risk emerged over several days and continued to grow for several months, indicating that **suicidal ideation was an enduring vulnerability rather than a short-term crisis (Simon et al., 2013).**”

**How we manage and respond to that risk should include strategies to address both the short term crisis** (e.g., hospitalization if needed, or rapid referral, safety planning & counseling on access to lethal means) **AND the long term vulnerability** (e.g., safety planning and referral even for medium to low risk individuals, caring contacts, repeat screenings).

# **Solving Our Common Problem:**

**Screening with the C-SSRS and  
Making Data Driven Policy to Save  
Lives**



# Adam Lesser, LCSW

***Deputy Director  
The Columbia Lighthouse Project***



Adam Lesser is a licensed clinical social worker, Assistant Professor of Clinical Psychiatric Social Work in the Division of Child and Adolescent Psychiatry at Columbia University Vagelos College of Physicians and Surgeons and the Deputy Director of the Columbia Lighthouse Project at the New York State Psychiatric Institute where he is responsible for all suicide prevention activities related to public health including the international dissemination and training for the Columbia Suicide Severity Rating Scale (C-SSRS). He has published, presented internationally and consulted to state and local governments on best practices for suicide risk identification and prevention. His work has been featured in Social Work Today Magazine and on Atlanta National Public Radio, CNN-espanol, Univision and other local print and television media outlets.



# Need to Screen Like Blood Pressure

Nearly 50% of people  
who die by suicide see  
their primary care doctor  
the month before they die

2/3 adolescent attempters  
in ER not present for  
psych reasons

**A VITAL OPPORTUNITY  
FOR PREVENTION**



**If we ask, we can reach those  
who suffer.**

# The High Cost of NOT Screening:

- 1,000 Non-Psychiatric Screened at Colorado University

Prior:

*400% increase in hospitalizations*

over past 2 years

*300% increase in ED visits*

**Look at what happens when you do**

**Centerstone: largest provider of outpatient community behavioral healthcare in US reduced ED recidivism from 40% to 7%**

# Screening Programs are Successful

- Meta-analysis concluded that **screening results in lower suicide rates in adults** (Mann et al., JAMA 2005)
- Elderly primary care screenings - **118% increase in rates of detection and diagnosis of depression** (Callahan et al., 1996)
- High school **screening identified 69% of the students with significant mental health issues** compared to clinical professionals who identified only 48%. **When both screening and professional referral were used 82% were identified** (Scott et al., 2009)
- College Screening Project - data suggest that screening brings high-risk students into treatment
  - Only **1 suicide in 4 years post-screening** vs. 3 suicides in 4 years pre-screening program (Haas et al., 2008)

# Why Screen? So Many Examples and the Clear Case For Universal Screening

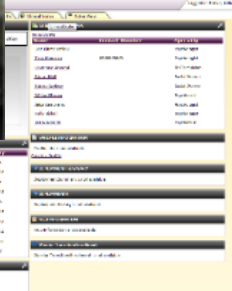


Parkland  
**First-Ever Universal  
Screening uses the  
C-SSRS at Parkland  
Memorial Hospital  
only 1.8% of  
100,000 Patients**

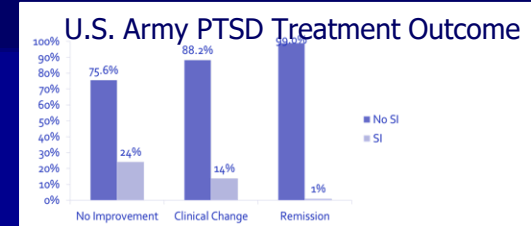
- Policy - used in every soldier-soldier and leadership-soldier interaction.
- Periodic Health Assessment - Over 3000 screenings completed in **PHA** identifying 11 soldiers needing assistance.
- **No suicides** in any of those screened



# Screening and Reducing Stigma Saves Lives in the US Army



**Nearly  
3 Million  
Screens**



***Data leads to additional funding***

Military, highest risk post-hospitalization – struggle to reintegrate into unit, stigma, false sense of recovery so this prevents post-hospitalization risk sequelae

- Treatment no longer a stigmatizing outpost
- Mental health questions integrated into other care
- Inpatient overnights reduced **41%** saving **30-40 million dollars** since 2012
- Decrease in suicide

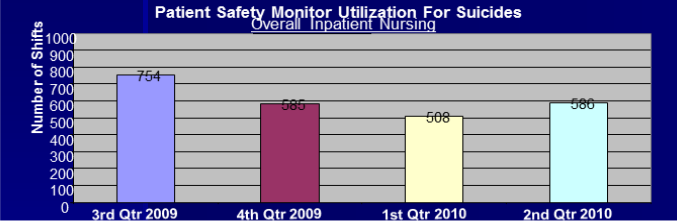
# Screening with Evidence Supported Thresholds for Imminent Risk Reduction of Workload

## Why C-SSRS?

- Reduce Suicide
- Reduce Workload
- Reduce Liability

Only Approx 1% require next step

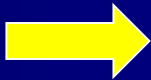
Reading Hospital: IMPROVED IDENTIFICATION WHILE REDUCING UNNECESSARY ONE-TO-ONES



**Dramatically reducing unnecessary interventions NEXT STEPS**

*Suicide watch goes down and police do not have to hospitalize*

**Indicates Need for Next Step**



## COLUMBIA-SUICIDE SEVERITY RATING SCALE Emergency Department - Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS		Past month	
Ask questions that are <b>bolded</b> and <u>underlined</u> .		YES	NO
<b>Ask Questions 1 and 2</b>			
1) <b>Wish to be Dead:</b> <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>			
2) <b>Suicidal Thoughts:</b> <u>Have you actually had any thoughts of killing yourself?</u>			
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.			
3) <b>Suicidal Thoughts with Method (without Specific Plan or Intent to Act):</b> E.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it." <u>Have you been thinking about how you might do this?</u>			
4) <b>Suicidal Intent (without Specific Plan):</b> As opposed to "I have the thoughts but I definitely will not do anything about them." <u>Have you had these thoughts and had some intention of acting on them?</u>			
5) <b>Suicide Intent with Specific Plan:</b> <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>			
6) <b>Suicide Behavior Question:</b> <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. <b>If YES, ask: Was this within the past three months?</b>			
			<b>Lifetime</b>
			<b>Past 3 Months</b>

Score: 0 Behavioral Health Referral at Discharge

Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions

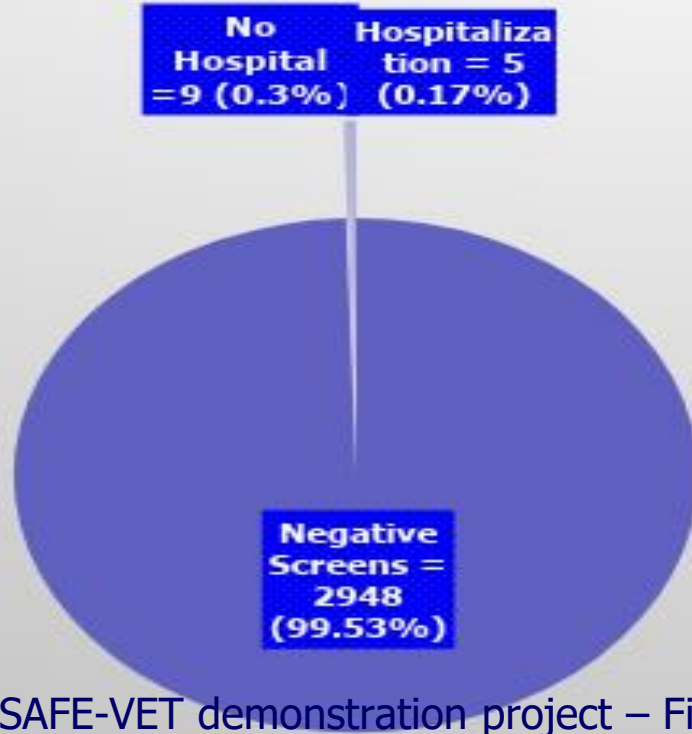
Item 4 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

Item 5 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

Item 6 Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions

Item 6 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

# Screening Vets with C-SSRS: Only 5/3000 High-Risk Vets Required More Acute Care



Only 14 out of 2962 screened positive (.47%)

Only 5 (.17%) required more acute care

VA SAFE-VET demonstration project – First large-scale study of C-SSRS in the VA Bridget Matarazo and Lisa Brenner Severity, Intensity and Behavior subscales predict suicidal behavior 6 months later



# The Importance of Tracking and Alerting With EHR

1. This is the current functionality in MHARS that will show the patient's name in red with an exclamation point, if there is a warning for this patient. Applies to all warnings, not just suicide risk.

2. This is our new suggestion to show the agreed upon text if the patient has a current alert based off the C-SSRS. There will be a hover that will state, "Go to Suicide: C-SSRS under MHARS links on the left hand side."

3. The description will show all the behaviors that have been selected for this patient throughout their lifetime. If they have a Warning, 'YES' will be displayed in the Warning column.

4. To get more details, the user would select the C-SSRS icon on the left hand side. This would bring them to the C-SSRS main page. See other mockup for further details.

*Risk  
Info  
Travels*

- 4/5 past month OR behavior past 3 months = highest level "SUICIDE WARNING"
- 4/5 OR behavior ever = "SUICIDE HISTORY" – suicidal risk elevated

**New York State  
Electronic Medical Record**



# The Power of Screening: Look at the Effect This Has Already Had in Largest Community BH System in US

The largest provider of outpatient community behavioral healthcare in the United States **reduced their suicide rates 65%** over 20 months.

**U.S. News** & WORLD REPORT

**ZERO**Suicide  
IN HEALTH AND BEHAVIORAL HEALTH CARE

## Screening Protocol at Centerstone

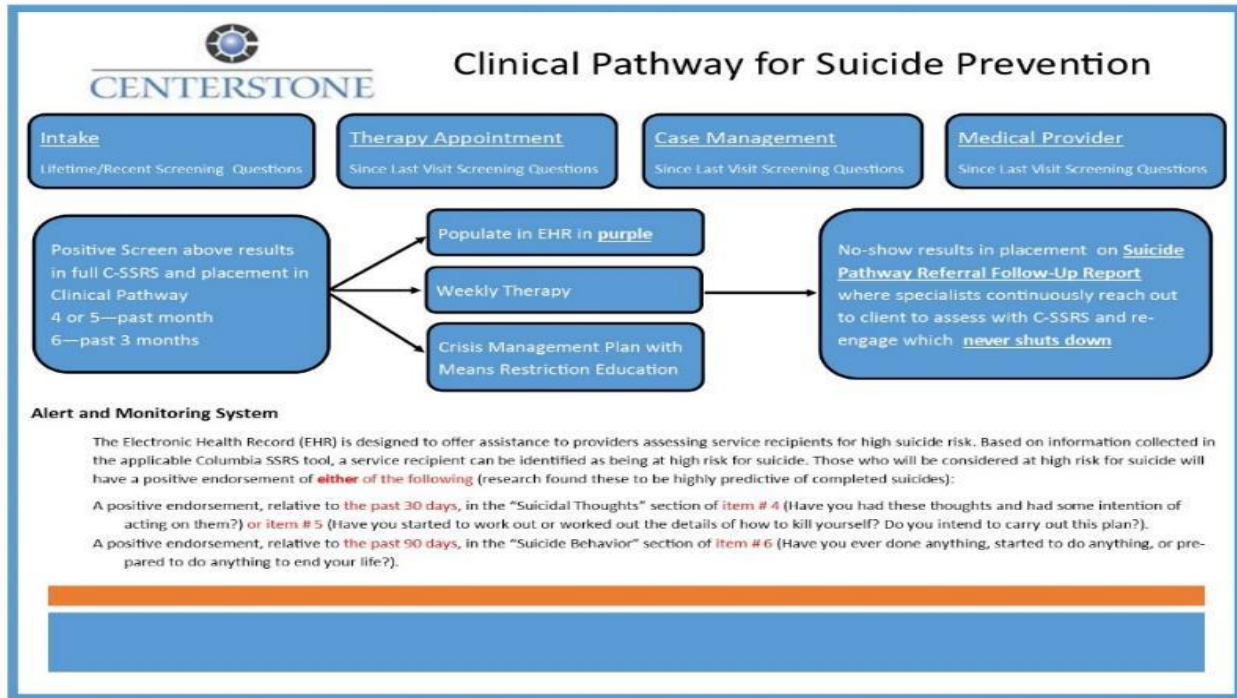
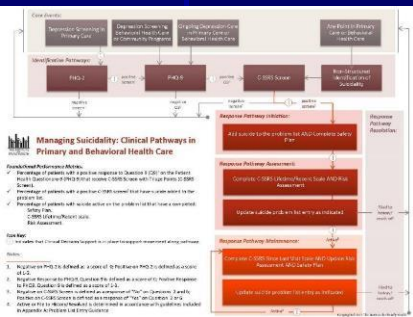


Taking on responsibility for identifying all patients at risk of suicide.



# Well Delineated Streamlined Big System Alerting Policies Optimizing Identification of Those at Imminent Risk “with so many patients its like mining for gold and the Columbia is the sifter”

Alerting System... suicide  
reduction in primary care



# Overcoming the Barriers to Screening: Fear and Liability

**"I'm afraid to ask because I don't know what to do with the answer."**



The Columbia Lighthouse Project/Center for Suicide Risk Assessment

## The Columbia Suicide Rating Scale

Supporting Evidence

THE COLUMBIA SUICIDE SEVERITY RATING SCALE

TABLE 1: STUDIES SUPPORTING SPECIFIC PSYCHOSOCIAL INTERVENTIONS

TABLE 2: PSYCHOMETRIC PROPERTIES OF SPECIFIC RATING SCALES

THE COLUMBIA SUICIDE SEVERITY RATING SCALE

TABLE 3: C-SSRS AS INTERVENTION AND MEASURE OF DIAGNOSIS AND TREATMENT

REPRESENTATIVE PUBLICATIONS FOR C-SSRS USE: POPULATIONS, SETTINGS, TREATMENT EFFICACY AND ASSESSMENT GUIDELINES

PEDIATRIC POPULATIONS BY AGE GROUP

MEDICAL SPECIALTIES

Neurology

Oncology

PSYCHIATRIC CONDITIONS

Alzheimer's

Autism

Bipolar Depression

Complicated Grief

Psychosis

PTSD

HEALTHCARE SETTINGS

OUTPATIENT SETTINGS

Outpatient Psychiatry

Juvenile Justice

Integrated Primary Care

Veterans

IN-PATIENT SETTINGS/EMERGENCY

MEDICATION TREATMENT EVIDENCE

REVIEWS OF SUICIDE RISK ASSESSMENT

GUIDELINES FOR TREATMENT

LINGUISTIC AND PSYCHOMETRIC

CROSS-CULTURAL SETTINGS

**Protects against liability: Internal and External**

**"If a practitioner asked the questions... It would provide some legal protection"**

**–Mental Health Attorney, Crain's NY**

- **Approx. 100 studies supporting across cultures, properties and sub-populations**
- **Close to 1000 published studies in last 5 years alone**

## Highlights of Predictive Evidence

# Posner et. al. AJP 2011

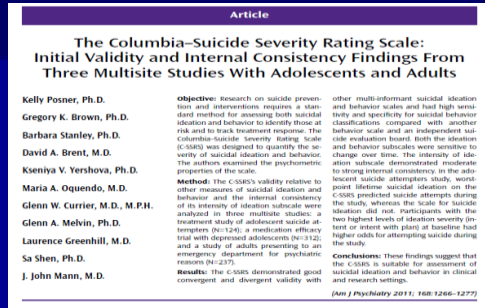
- Lifetime Ideation, types 4 and 5, predicted suicide attempts in adolescent suicide attempters, followed over a year

## Beck SSI NOT predictive

- Lifetime Ideation, types 4 and 5, predicted actual, interrupted or aborted attempts

Mundt et. al., JCP 2013

- Patients with baseline prior ideation of 4 or 5 or prior behavior are 4-5x more likely to report suicidal behavior at follow up
- *Patients with both are 9x more likely to report suicidal behavior*



# Each Type of Ideation Severity Confers Increasingly Greater Risk

History of Lifetime Suicidal Ideation at Study Start	All Patients N=8837 OR (95% CI)	Psychiatric Patients N=6760 OR (95% CI)
No Ideation Reported	0.8% incidence rate N=4975	1.1% incidence rate N = 3184
Wish to Be Dead	6.21 (4.18 – 9.23)*** N=1491	4.99 (3.29 – 7.56)*** N = 1351
Non-Specific Active Suicidal Thoughts	6.69 (4.16 – 10.76)*** N=635	5.53 (3.38 – 9.04)*** N = 568
Active Suicidal Ideation with Any Methods (Not Plan), without Intent to Act	11.16 (7.43 – 16.76)*** N=775	8.36(5.44 – 12.84)*** N = 725
Active Suicidal Ideation with Some Intent to Act, without Specific Plan	19.27 (12.97 – 28.63)*** N=581	15.24 (10.07 – 23.09)*** N = 545
Active Suicidal Ideation with Specific Plan and Intent	25.53 (16.94 – 38.47)*** N=398	18.70 (12.16 – 28.76)*** N = 387

# Data Supports Importance of Full Range:

## All Lifetime Suicidal Behaviors Predict Suicidal Behavior

Behavior reported at baseline	Patients not prospectively reporting suicidal behavior	Patients prospectively reporting suicidal behavior	Odds ratio of prospective suicidal behavior report (95% CI; *** <i>p-values</i> < .001)
Actual Attempt	522 (85.6 %)	88 (14.4 %)	4.56 (3.40 – 6.11)***
Interrupted Attempt	349 (82.7 %)	73 (17.3 %)	5.28 (3.88 – 7.18)***
Aborted Attempt	461 (84.7 %)	83 (15.3 %)	4.75 (3.53 – 6.40)***
Preparatory Behavior	177 (81.2 %)	41 (18.8 %)	4.92 (3.38 – 7.16)***

A person reporting any one of the lifetime behaviors at baseline is ~5X more likely to prospectively report a behavior during subsequent follow-up

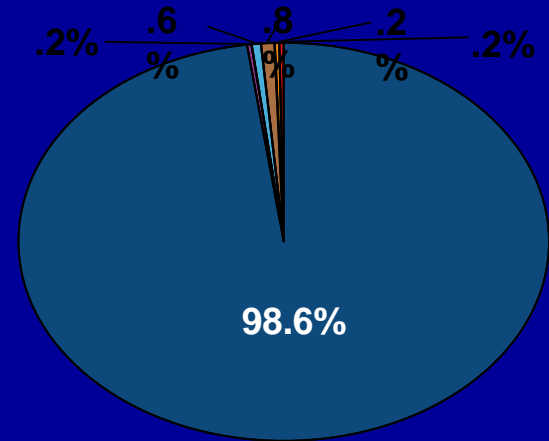
# ALL Behaviors Are Prevalent and Predictive

***Each behavior  
is EQUALLY  
PREDICTIVE***

***to an attempt  
Multiple behaviors = greater risk***

No Behavior: 28,303  
Actual Attempt: 70  
Interrupted Attempt: 178  
Aborted Attempt: 223  
Preparatory Behavior: 71

**n = 28,699 administrations**



*Mundt et al., 2011*

**\*Only 1.7% had any worrisome answer**

**472 Interrupted, Aborted and Preparatory (87%)  
vs. 70 Actual Attempts (13%)**

# Benefit of using standardized tools for screening and assessment

- **Brent et al., (2009):** Treatment-resistant, depressed adolescent suicide attempters (N=334, ages 12-18)
  - Higher rates of suicidal (20.8% vs. 8.8%) and non-suicidal self-injury (17.6% vs. 2.2%) detected with systematic monitoring using the C-SSRS
- **Arias et al. (2013):** 497 ER adult patients with suicidal thoughts or attempt(s)
  - 41% increase in the detection of suicide attempts compared to chart reviews (59% vs. 18%, difference of 41%) using the C-SSRS



# Open-Ended Clinical Interview vs. the C-SSRS



Clinicians administered the C-SSRS to 201 in-patient admissions with MDD

- 29.7% of patients with suicidal ideation
- 18.7% of patients with history of attempt

were undetected by clinician interview.

*Bongiovi-Garcia et al., 2009*

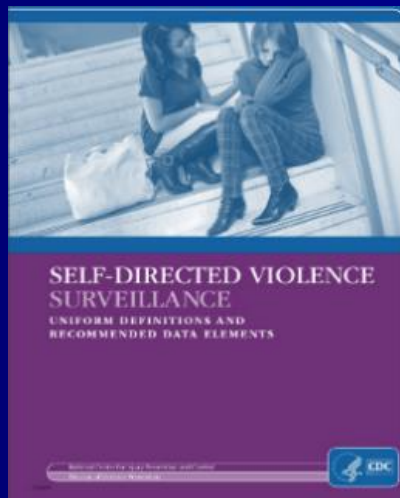
# Adopted by CDC

## "The Need for Consistent Definitions & Data Elements"

### The Importance of a Common Language

"The C-SSRS is changing the paradigm in suicide risk assessment in the US and worldwide" – Alex Crosby

" Research on suicide is plagued by many methodological problems... Definitions lack uniformity,... reporting of suicide is inaccurate..."  
*Reducing Suicide* Institute of Medicine 2002



Also from CDC:  
"Unacceptable Terms"

- *Completed suicide*
- Failed attempt
- Parasuicide
- *Successful suicide*
- Suicidality
- Nonfatal suicide
- Suicide gesture
- Manipulative act
- Suicide threat

Source: Posner K, Oquendo MA, Gould M, Stanley B, Davies M. Columbia Classification Algorithm of Suicide Assessment (C-CASA): Classification of Suicidal Events in the FDA's Pediatric Suicidal Risk Analysis of Antidepressants. *Am J Psychiatry*. 2007; 164:1035-1043.  
<http://cssrs.columbia.edu/>

# Why it's good to do one thing...

## "Science and the Public Health Demand Uniformity"

(Gibbons, NCDEU 2010)

- Moving away from a single instrument inherently degrades the precision of the signal
- The impact of *imprecision grows when incidence rates are low*
- 1% vs. 3% - misclassification of 1 or 2 cases can have a profound impact, affect ratios, and substantially alter conclusions
- Even if you assume two equally valid measures, more measurement variability, more noise

***Take away: Multiple measures increase noise, decrease precision and weaken rigor of data***

# C-SSRS... Vital Signs

Joint Commission and the C-SSRS



[Hospitals and health care systems] have either developed something themselves or they're using a piecemeal approach, with different tools in different departments: What may appear to be a person at risk in one area may not appear to be at risk in another. **When the ED is asking their set of questions, and then the social worker asks another set, then the psychiatrist asks another, you're reducing the signal strength. You're not honing in on the needle in the haystack.**

"The research shows that **this tool** will help organizations **focus on folks who are at highest risk.**"

"By adopting the C-SSRS, organizations ensure that **one tool is being used by all caregivers**, who can then use the same terminology when communicating with other caregivers...Using **the same language helps all caregivers** understand what the patient needs."



Cleveland Clinic

# Improving Suicide Screening at the Cleveland Clinic through Electronic Self-Reports: PHQ-9 and the Columbia-Suicide Severity Rating Scale (C-SSRS)

Irene L. Katzan<sup>1</sup>, M.D.; Adele C. Viguera<sup>1</sup>, M.D., M.P.H.; Taylor Burke<sup>2</sup>, B.A.; Jacqueline Buchanan<sup>2</sup>, A.B.; Kelly Posner<sup>2</sup>, Ph.D.

<sup>1</sup>Cleveland Clinic <sup>2</sup>Columbia University Medical Center



## Cannot Rely on Triggering Then You'll Miss People At-Risk

### Improved Identification with Decreased False Positives

PHQ-9 Suicide Item: Thoughts that you would be ***better off dead*** or of ***hurting yourself*** in some way

Outpatient Psychiatry Pilot – Self Report Computer Version (523 Encounters)

- 6.2% positive screen on C-SSRS
- vs.
- 23.8% endorsed item #9 of PHQ-9

Most, but not all, of the positive Columbia screen patients endorsed #9 of PHQ9 e.g. Cases were missed

# **The Importance of Screening Beyond Medicine: The Urgent Need For a Public Health Approach**

## **Medical Model**

- **Narrow approach**
- **Mental health treatment by clinicians in hospitals & clinics**
- **Most people at risk do not seek specialized treatment**

## **Public Health Model**

- **Broad approach**
- **Target: whole community**
- **Training of all gatekeepers**
- **Across all health services**

# Everyone, Everywhere Can Ask and Needs to Ask



**VT - Policy  
recommendatio  
n and roll play  
for school  
janitors**

**Zero suicide  
community  
workshop for  
custodians and  
receptionists**



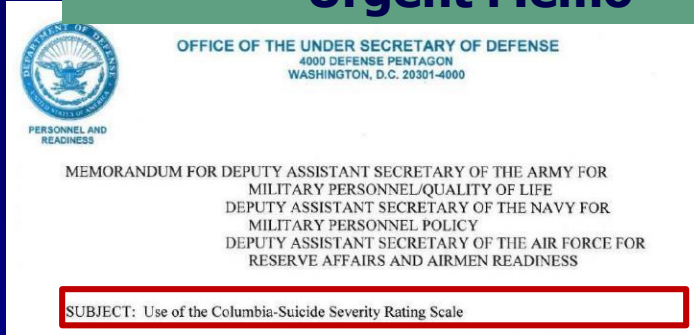
"This is prevention for the masses now, not just the educated, the wealthy or those in the medical field. It is available and accessible for all of humanity."



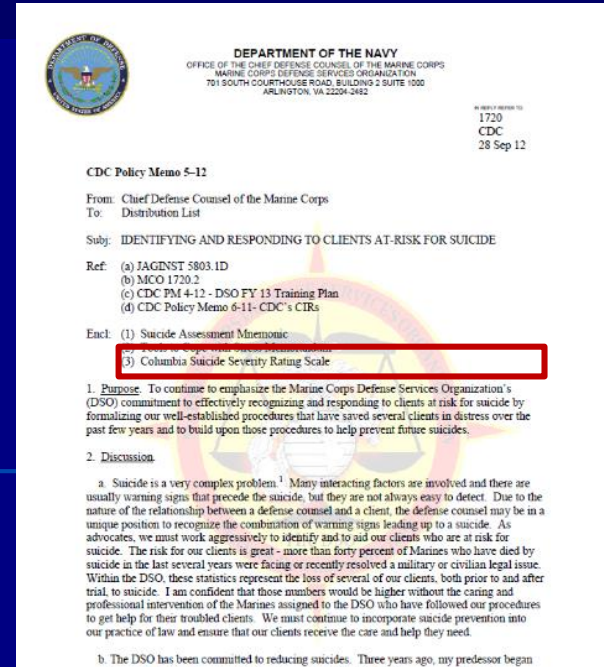
# Must Go Beyond the Medical Model Towards a Community Approach: Marines Reduce Suicide by 22%



## Undersecretary of Defense Urgent Memo



- **Total force roll-out**
- Force Preservation
- Trained 16 installations including Okinawa
- In the hands of whole community
- **ALL support workers:** lawyers, financial aid counselors, chaplains, family advocacy workers, substance abuse specialists, victim advocates





# Linking of Systems

## Department Health & Mental Health

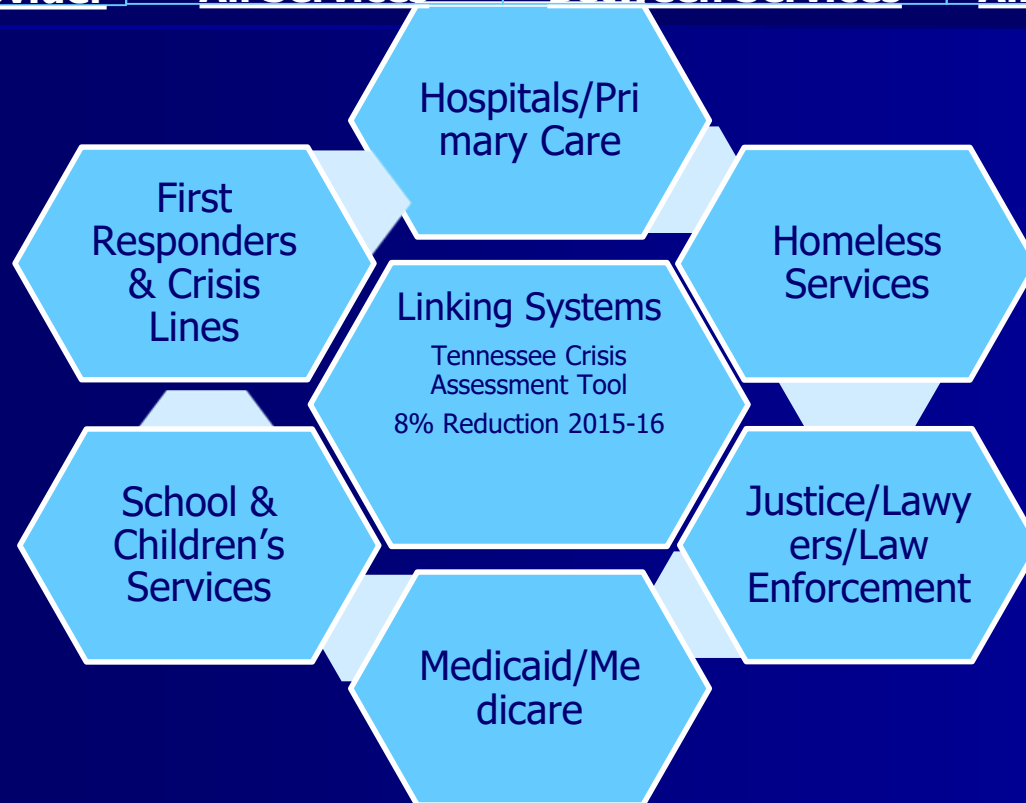
**Provider by Provider**

**All Services**

**Between Services**

**All Systems of Care**

**Policy at the  
state level,  
even  
legislation**



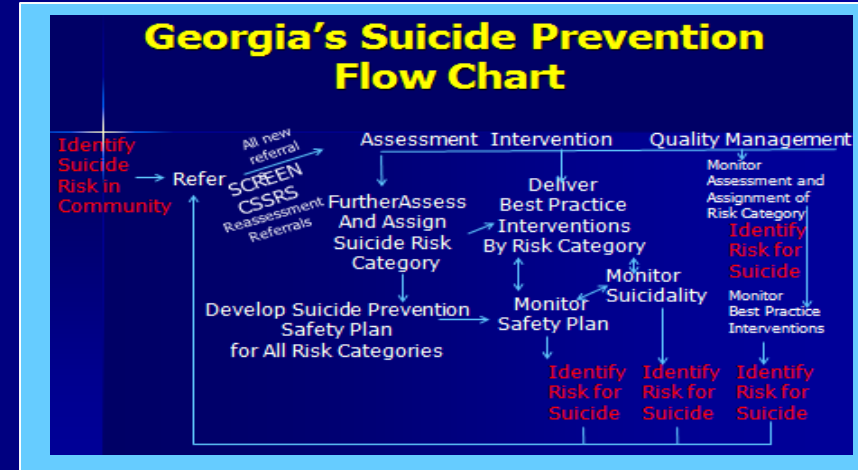
"...made a big difference. Historically, "turfed out" to their psychologist. However, after the entire team ....discussions about suicide became more team wide and robust. Everyone was now providing observations and ideas about suicide risk management and wanting to take responsibility for client care." – OMH, NY

# Statewide Policy

## "AIM" Assessment, Intervention and Monitoring

### Georgia DBHDD Implementation Plan

1. Introduced Statewide
2. Overview by Region and regional support
3. Policy development at state level for **all Medicaid providers**
4. Provider by Provider implementation
5. Providers implement in all services, between services, and in systems of care
6. Lifeline Crisis Call Center



# Texas:

## Top Down Implementation

- **Recommended tool for “suicide safer care”** endorsement from state for local mental health authorities
- Universal assessment process for access to the public mental health system (**embedding C-SSRS IN EXISTING TOOLS**) – Child and Adolescent Needs and Strengths (CANS)  
Adult Needs and Strengths Assessment (ANSA)
- Mobile crisis units and hotlines
- Psychiatric Emergency Walk in Centers
- Mobile Crisis Teams
- Physical Health/ Behavioral Health Integrations projects
- Suicide Safer Schools Model system

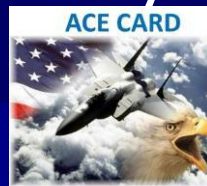
**NOT YET TRICKLED DOWN TO EVERYONE**

# Whole-Community Systems Approach in the Air Force: Airman, Dentist, Spouse -- Everyone Asking



## Support Workers

- Clergy
- Legal Assistants
- Financial Aid Counselors
- Advocates
- Case Managers



## Peers & Leadership



## Security/Safety

- Overnights
- Explosive Ordinance Disposal
- Military Police



## Behavioral Health



When A  
Community  
Comes  
Together There  
is Hope

## Schools, Child & Family Services

## Primary Care, Dentistry

## Spouses



For questions and other inquiries,  
email: [kelly.posner@nyspi.columbia.edu](mailto:kelly.posner@nyspi.columbia.edu)

Website address for more information:  
[www.cssrs.columbia.edu](http://www.cssrs.columbia.edu)

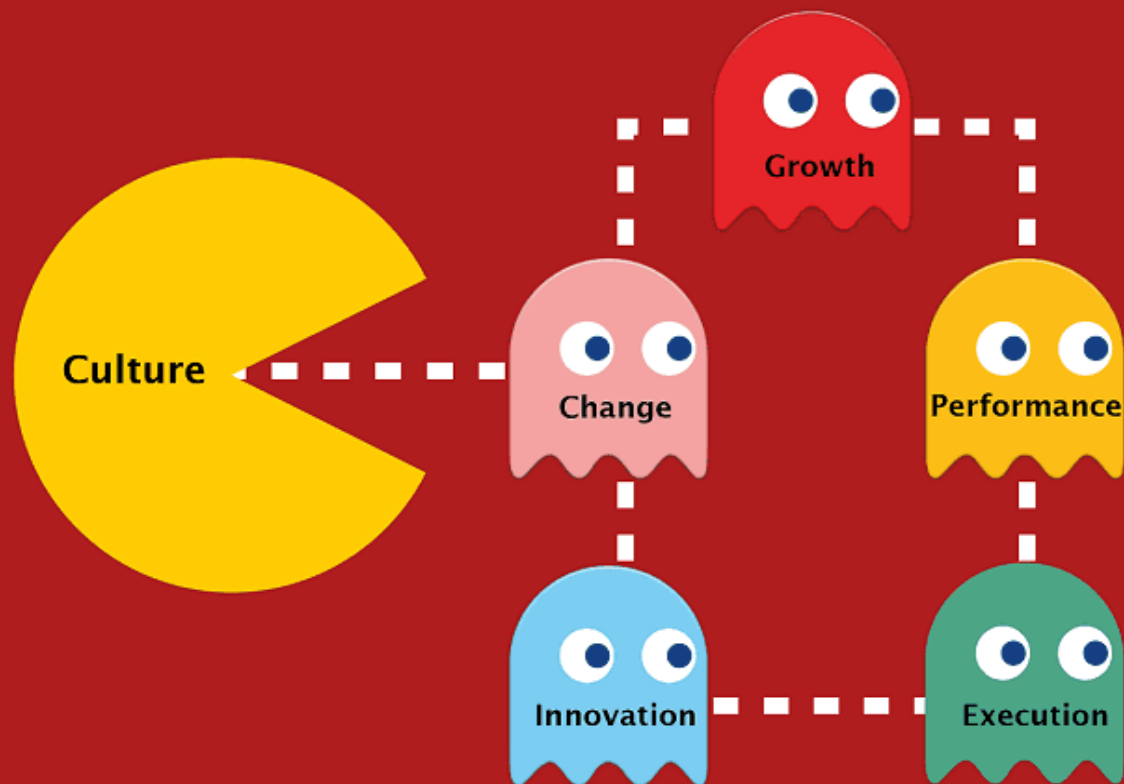
# The How- 30 Minutes

Kim Myers: 10

Kim McComas: 20

Q&A/Discussion: 10

# Organizational culture eats strategy for breakfast, lunch and dinner



THE TOOLS OF ZERO SUICIDE FILL THE GAPS





# ZS Best Practices in Screening and Assessment

Is it in written policy and required?

Is it in the EHR?

Is it an evidence based standardized tool?

Are all relevant staff trained on it regularly?

Is screening implemented at intake, at all visits for those at risk, and when a change in risk status is observed?

Is a comprehensive clinical risk assessment provided the same day risk is identified?

Is risk reassessed and integrated into treatment sessions for every visit for individuals with risk?

## 12. Systematically identify and assess suicide risk:

What are the organization's policies for **screening** for suicide risk?

» Please select the number where your organization falls on a scale of 1–5.



**1**

There is no systematic screening for suicide risk.



**2**

Individuals in designated higher-risk programs or categories (e.g., crisis calls) are screened.



**3**

Suicide risk is screened at intake for all individuals receiving behavioral health care.



**4**

Suicide risk is screened at intake for all individuals receiving either health or behavioral health care and is reassessed at every visit for those at risk.



**5**

Suicide risk is screened at intake for all individuals receiving health or behavioral health care and is reassessed at every visit for those at risk. Suicide risk is also screened when a patient has a change in status: transition in care level, change in setting, change to new provider, or potential new risk factors (e.g., change in life circumstances, such as divorce, unemployment, or a diagnosed illness).

# Zero Suicide Screening Policy/Procedure

1. **Policies and procedures clearly describe screening patients for suicide risk, including:**
  - a. The frequency of screening
  - b. Documenting risk screenings
  - c. Screening and identification workflows
  - d. How staff will be alerted when their patients screen positive for suicide risk
2. A written policy and procedure specifies that **patients are provided timely access to clinically trained staff** after screening positive for suicide risk.
3. A standardized screening measure is used by all staff.
4. Staff receives formal training on suicide screening and documentation.
5. In inpatient treatment, in addition to the above:
  - a. Patients are screened prior to discharge.

# Zero Suicide Risk Assessment Policy/Procedure

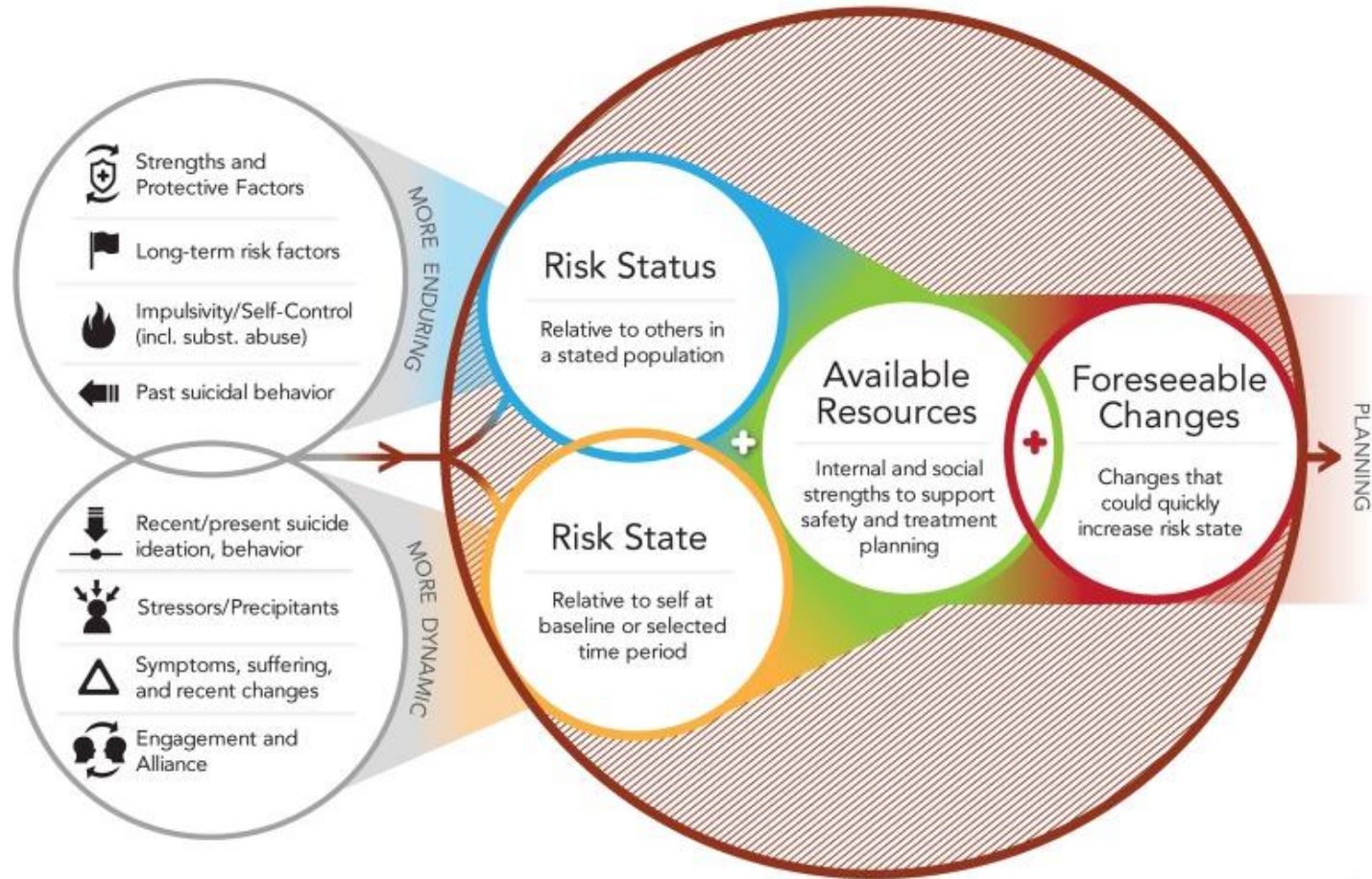
1. A written policy and procedure states that a comprehensive suicide risk formulation is completed during the same visit whenever a patient screens positive for suicide risk.
2. All staff use the same risk formulation model.
3. The comprehensive risk formulation is conducted by a trained clinician.
4. All clinical staff receive formal training on risk formulation and documentation.
5. Information for risk formulation is taken from multiple sources, including treatment professionals, case workers, and people who are significant in the patient's life.
6. Risk formulation decisions are based on observations by multiple staff members.
7. The risk formulation is reevaluated and documented in the patient's record at every client visit.

# Risk Formulation: From Prediction to Prevention

<p>From:</p> <p>Categorical Predictions of</p> <ol style="list-style-type: none"><li>1. Low</li><li>2. Medium</li><li>3. High</li></ol>	<p>To:</p> <p>Judgments to directly inform intervention plans</p> <ol style="list-style-type: none"><li>1. risk status (the patient's risk relative to a specified subpopulation)</li><li>2. risk state (the patient's risk compared to baseline or other specified time points)</li><li>3. available resources from which the patient can draw in crisis, and</li><li>4. foreseeable changes that may exacerbate risk</li></ol>
---	--

# Clinical data

# Risk Formulation



# Interpersonal Theory of Suicide

## Perceived Burdensomeness

Feeling ineffective to the degree that others are burdened is among the strongest sources of all for the desire for suicide.

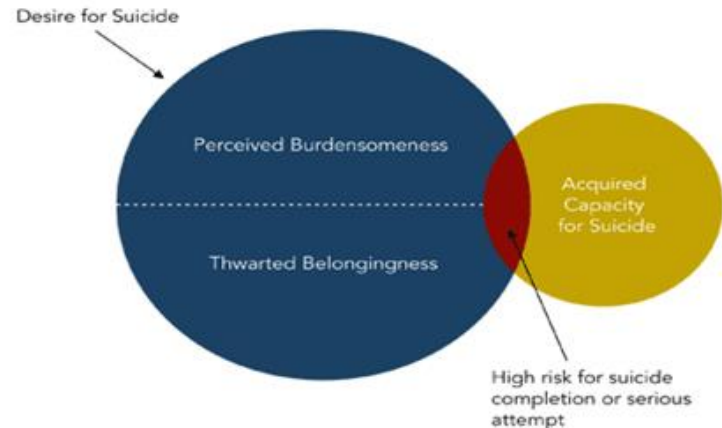
## Thwarted Belongingness

Our need to belong to valued groups and relationships is so powerful that, if frustrated or thwarted, serious negative health consequences follow – including suicide. Hopeless alienation

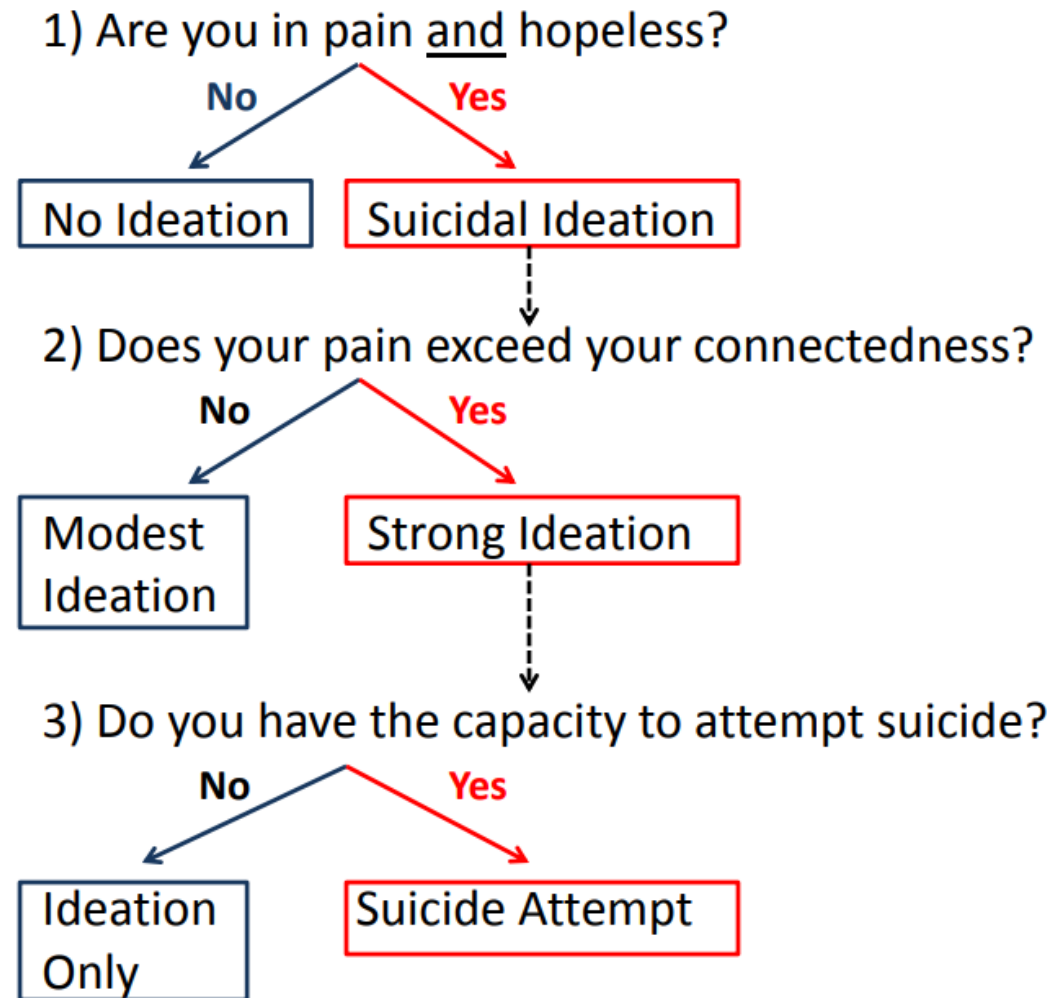
## Suicidal Capacity

- Disinhibit from fear of death
- Fearlessness
- Painful experiences across life

Figure 1



# Ideation to Action Framework





## Centerstone Standard Operating Procedure: Suicide Risk Assessment

This document outlines the standard operating procedure for suicide risk assessment at Centerstone of Tennessee. The document supports Centerstone's policy that all individuals be screened for suicide risk at every service contact during the course of treatment.

### CENTERSTONE

#### Standard Operating Procedure: Suicide Risk Assessment

Consistent with Centerstone policy all service recipients shall be screened for suicide risk at intake and every subsequent service contact with Centerstone providers during the course of treatment.

##### Points of Contact:

###### Intake:

During the course of an intake appointment every service recipient will be screened for suicidal risk with the following steps:

- During the course of the recipient's intake a Master's level clinician will perform the Columbia Suicide Severity Rating Scale (C-SSRS) to screen for suicidal risk:
- If the answer to both C-SSRS "Lifetime or Recent" questions is "no", there is no further need to continue with the tool and the intake will continue.
- If there is a "yes" response to either the "Lifetime or Recent" screening questions the clinician will proceed with administering the rest of the C-SSRS assessment tool.
- The clinician will then be prompted by the C-SSRS tool and CenterNet for proceeding with completion of the assessment and enrollment in the Suicide Prevention Pathway.

###### Therapy Appointment:

During the course of a routine therapy appointment every service recipient will be screened for suicidal risk with the following steps:

- At the service point, with the client present a Master's level clinician will administer the C-SSRS assessment tool.
- If the answer to both C-SSRS "Since Last Visit" questions is "no", there is no further need to continue with administering the tool and the routine appointment will continue.
- If there is a "yes" response to either "Since Last Visit" screening questions the clinician will proceed with administering the rest of the C-SSRS assessment tool.
- The clinician will then be prompted by the C-SSRS tool and CenterNet for proceeding with completion of the assessment and enrollment in the Suicide Prevention Pathway.
- Enrollment proceedings are required to be adequately documented within the progress note: Please refer to **The Source-Documents-Forms-Suicide Pathway Documentation Reminders** for recommended documentation standards.

## Centerstone Standard Operating Procedure: Suicide Risk Assessment

Outlines policies for all points of  
contact:

- Intake
- Therapy
- Case Management
- Medical Provider
- Crisis Contact

Outlines Clinical Care Pathway for  
Suicide Prevention including an alert  
and monitoring system

Staff Training Requirement



# Suicide Prevention Project

Kim McComas, LCSW

Davis Behavioral Health



# Description and Scope of Project

- Two main goals:
  - Universal screening for suicide risk using the Columbia Suicide Severity Rating Scale (C-SSRS) – **INDICATOR 1**
  - Same day safety planning using the Stanley Brown safety plan for those identified as at-risk – **INDICATOR 2**
- Three year time period (January 1, 2015 – December 31, 2017)
  - 2015 – Baseline measurement period
  - 2016 – Remeasurement year 1
  - 2017 – Remeasurement year 2



## **Baseline Measurement Period (2015)**

- Only the crisis team was using the C-SSRS at this time (and this was not consistent)
- No standardized safety plan – varied immensely across programs
- No standardized criteria for when a safety plan is indicated
- End of year results:
  - 286 clients screened out of 3601 total served (7.9%)
  - 149 clients received a same day safety plan out of 188 identified as at-risk (79.3%)



# **Remeasurement Year 1 (2016)**

## *Initial Interventions*

- Provided training to all clinical staff on the project, the C-SSRS, and the Stanley Brown safety plan
- Embedded the C-SSRS into the initial evaluation service
- Created a “Columbia” service in order to assess for suicidal risk at any point in treatment
- Created a “Safety Plan” service (Stanley Brown)
- Response to OQ/YOQ question on suicidal ideation required in the therapy notes



## **Remeasurement Year 1 (2016)**

### *What We Noticed*

- Immediate increase in number of clients screened (186 in January 2016 alone versus 286 for all of 2015)
- Despite the increase, there was still a low overall rate of screening
  - Clients receiving medication services only were being missed
- Clinicians were not completing the C-SSRS section of the evaluation
- Low rates of same day safety plans (41.5% for first half of year)



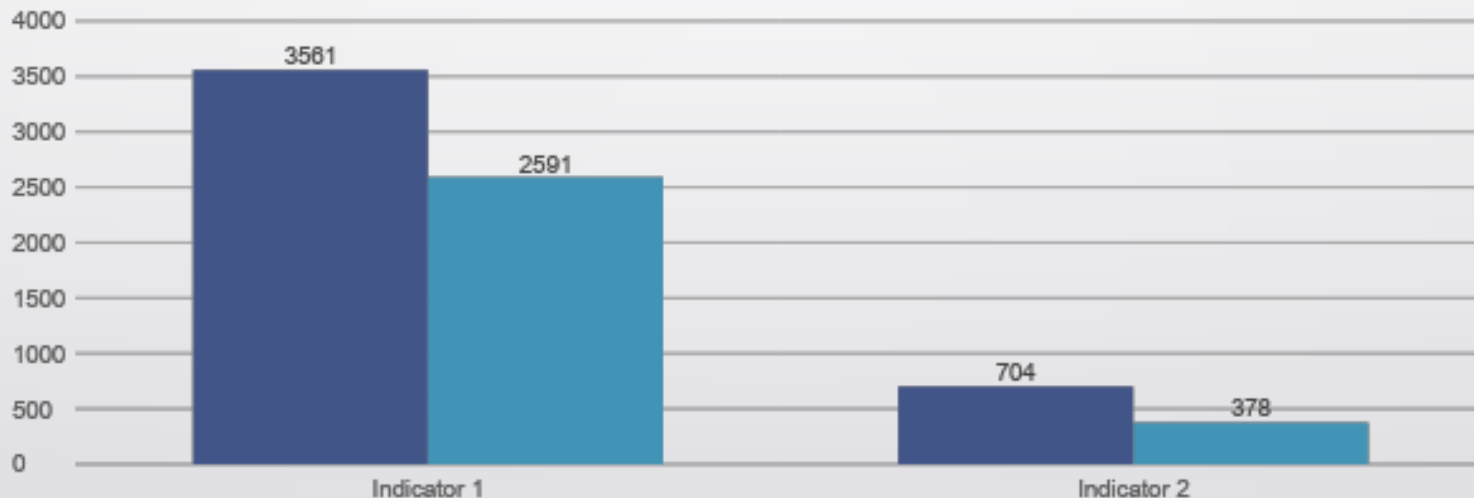
# **Remeasurement Year 1 (2016)**

## *What We Did About It*

- Solicited feedback from staff
- Implemented C-SSRS screener questions into medical services
- Made the C-SSRS a mandatory section of the evaluation
- Made the “Columbia” and “Safety Plan” services billable
- Use of peers
- Training, training, training and reminders, reminders, reminders

# Remeasurement Year 1 (2016)

*Final Results*





# Remeasurement Year 1 (2016)

*Final Results*





# **Remeasurement Year 1 (2016)**

## *Final Results – What Happened??*

- Low rates of same day safety planning within crisis services and medical services
- Staff turnover
- Continued issues with not completing C-SSRS (relatively small barrier)
- Misinformation regarding when a safety plan is indicated
- Significant push back from staff – variety of issues including:
  - Not clinically meaningful
  - Time consuming
  - Not helpful for clients with chronic SI
  - Technical barriers



# **Remeasurement Year 2 (2017)**

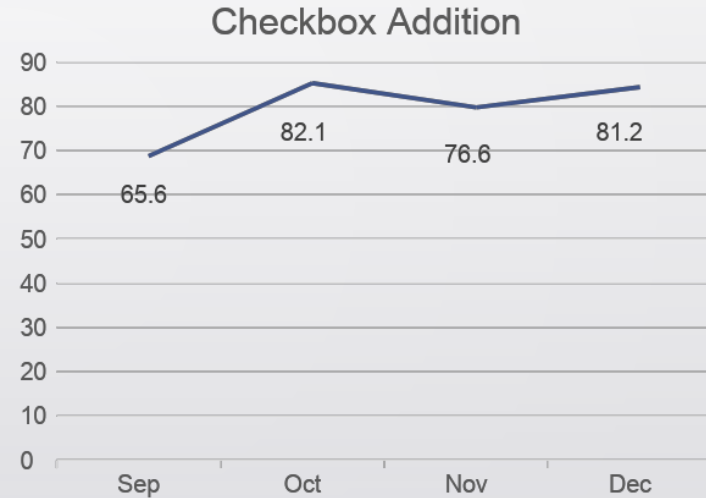
## *Interventions*

- Change in crisis procedures for short-term residential admits
  - Screened using C-SSRS at admission and discharge
  - Safety plans completed at admission and discharge if indicated
- Change in medical procedures for clients at-risk
- C-SSRS made a mandatory portion of evaluation
- Training for new employees
- Monthly data to supervisors
- Use of regularly scheduled consultation groups

# Remeasurement Year 2 (2017)

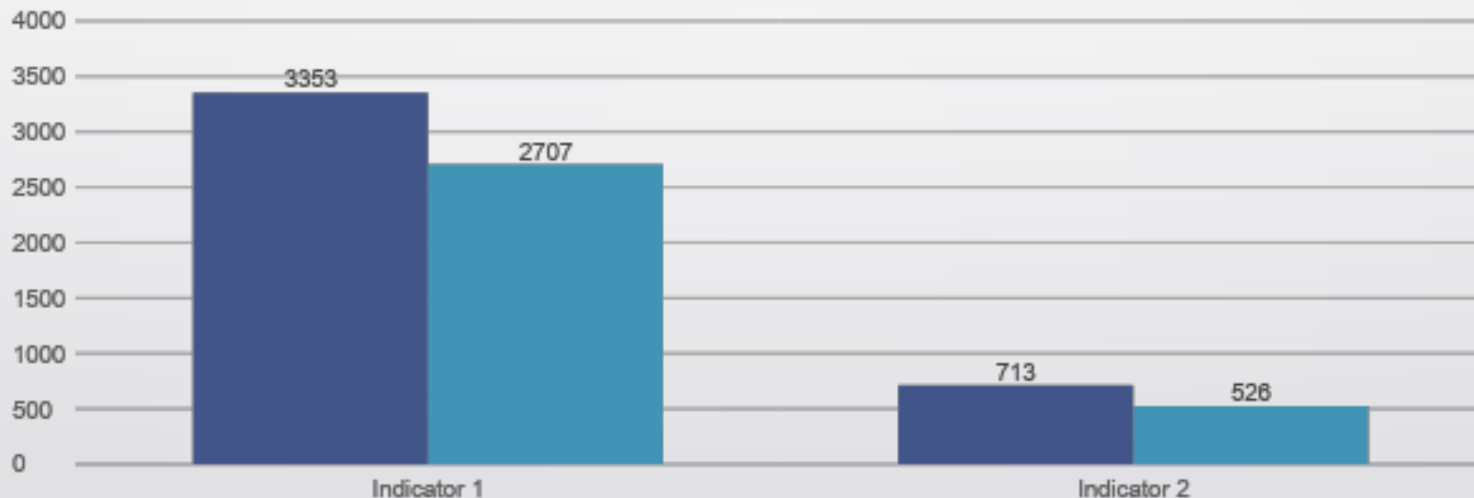
## *Unexpected Surprise*

- Cumbersome data collection process
- Added a checkbox in the evaluation and “Columbia” services
- Checked if a same day safety plan is indicated
- Purpose was to allow for more efficient data gathering



# Remeasurement Year 2 (2017)

*Final Results*



# Remeasurement Year 2 (2017)

*Final Results*





## **Key Takeaways**

### *And What We Still Struggle With*

- Biggest challenge is pushback from staff
- Often perceived mental barriers rather than actual ones
- Evaluate data often and on several levels
- Share the data
- Incorporate into the use of clinical models
- Ongoing training is key
- Reminders are needed for even the most well-intentioned

# Responding to Identified Risk

Next Meeting (May 16) will focus on this topic. But just to get you thinking:

“Response to item 9 of the PHQ-9 for depression identified outpatients at increased risk of suicide attempt or death. This excess risk emerged over several days and continued to grow for several months, indicating that **suicidal ideation was an enduring vulnerability rather than a short-term crisis (Simon et al., 2013).**”

**How we manage and respond to that risk should include strategies to address both the short term crisis** (e.g., hospitalization if needed, or rapid referral, safety planning & counseling on access to lethal means) **AND the long term vulnerability** (e.g., safety planning and referral even for medium to low risk individuals, caring contacts, repeat screenings).